

No. 84-495

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Supreme Court of the United States

October Term, 1984

**RICHARD THORNBURGH, H. ARNOLD MULLER, HELLEN
B. O'BANNON, MICHAEL J. BROWNE, WILLIAM
R. DAVIS, LEROY S. ZIMMERMAN, personally and
in their official capacities, and JOSEPH
A. SMYTH, JR., personally and in his official
capacity, together with all others similarly situated,**

Appellants,

vs.

**AMERICAN COLLEGE OF OBSTETRICIANS AND
GYNECOLOGISTS, PENNSYLVANIA SECTION; HENRY
H. FETTERMAN, M.D., THOMAS ALLEN, M.D., AND
FRANCIS L. HUTCHINS, JR., M.D. on behalf of
themselves and all others similarly situated;
ALLEN J. KLINE, D.O., on behalf of himself
and all others similarly situated;
BROOKS R. SUSMAN; PAUL WASHINGTON; MORGAN P. PLANT,
on behalf of herself and all others similarly
situated; ELIZABETH BLACKWELL HEALTH CENTER
FOR WOMEN; PLANNED PARENTHOOD OF
SOUTHEASTERN PENNSYLVANIA; REPRODUCTIVE
HEALTH AND COUNSELING CENTER; and
WOMEN'S HEALTH SERVICES, INC.**

Appellees.

**ON APPEAL FROM THE UNITED STATES
COURT OF APPEALS FOR THE THIRD CIRCUIT**

**BRIEF AMICI CURIAE OF OLIVIA GANS,
TERRYL CARLSON AND SUZI DEWING FOR
APPELLANTS RICHARD THORNBURGH, ET AL.**

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NOTE

This Brief Amici Curiae is filed with the consent of all parties to this appeal. A letter from each attorney stating this consent has been filed herewith with the Clerk of this Court.

STATEMENT OF INTEREST OF THE AMICI

The *amici* Olivia Gans, Terryl Carlson, and Suzi Dewing are women who procured abortions without being adequately informed of the nature of the abortion procedure, the medical risks involved, or the alternatives to abortion. The *amici* believe that if accurate information on the characteristics of their unborn children, the risks attendant on abortion, and the public and private agencies willing to assist them with childbirth, such as that prescribed by 18 PA. CONS. STAT. §§3205(a) and 3208, was made available to them at the time they sought their abortions, they would have decided against the procedure.

Olivia Gans obtained an abortion in New Jersey in 1981 at the insistence of her boyfriend. She spoke with four doctors and a Planned Parenthood counselor before undergoing the abortion, none of whom encouraged her to think about her decision and make her own choice. She heard only a cursory description of the abortion procedure, and the unborn baby was referred to merely as a "complication." By her own count she was 13-14 weeks pregnant, but she was told by the physician who performed the abortion that she was only in the third month of her pregnancy. No mention was made of any medical risks or possible psychological consequences of abortion.

Miss Gans' abortion was performed without anesthesia, yet she was not warned beforehand about the pain the procedure would entail. The method utilized was suction aspiration even though, as Miss Gans learned later, that procedure poses particular danger of bleeding and incomplete removal of the fetus for a woman more than twelve weeks pregnant. The cursory pelvic exam given her a week later was inadequate to detect possible uterine scarring or fallopian tube blockage resulting from an abortion, and Miss Gans does not know whether she suffered any long-term adverse physical effects. She has felt some of the psychological damages of an abortion: she found it difficult to hold a baby for two years after her

experience, and she has noted an inability to relax and relate romantically to a man.

Miss Gans now believes that if she had been given information on the development of her unborn child, on the risks accompanying a second-trimester abortion, and on the availability of childbirth assistance for a single woman like herself, she would not have proceeded with the abortion. Thus, in her view, her consent to her abortion was not an informed consent, and her decision to abort her unborn child was not the decision she would have made had she been fully informed.

Terryl Carlson was a 27-year-old single parent living in Idaho when she became pregnant with a third child in 1979. She was personally opposed to abortion, but was unable to bear the expenses associated with the birth of a baby. She unsuccessfully sought childbirth assistance from several feminist and governmental organizations. No one mentioned that as a full-time student without income who was already receiving Aid to Families with Dependent Children, she was probably eligible for childbirth assistance through Medicaid. She was told that she would be responsible for all childbirth medical expenses unless she gave the child up for adoption. She did not feel that adoption was an option for her because of the effect she feared it would have on her other two young children. Her student health insurance would pay for 75% of the cost of an abortion (\$150.00), but would pay only \$250.00 toward childbirth costs. She consulted her physician and was told that an abortion would entail no adverse consequences for her and that the fetus was simply a "mass of cells." Feeling that no other course of action was possible for her, she made a hasty decision to abort in the sixth or seventh week of her pregnancy. However, Miss Carlson remained uneasy about her decision and contemplated refusing the abortion even as she was being prepared for the procedure. She did not realize that the abortion was underway until she inquired about the vacuum noise she was hearing and was told it was

the sound made by the suction curettage machine which was being used to perform the abortion. She became hysterical when she realized it was too late to refuse the abortion.

Miss Carlson suffered serious post-abortion gynecological problems for four years. The additional psychological consequences of her abortion included guilt, anger, depression, loss of self-esteem, and suicidal tendencies. She feels that if printed materials documenting the development of the fetus and the risks of abortion had been made available to her, she would have read them and realized the fetus was not the mere "mass of cells" nor abortion the innocuous procedure she had been led to believe. Most significantly, because her financial situation was one of the major factors in her decision to abort, Miss Carlson would have been anxious to review any information on childbirth assistance and paternal responsibility. In sum, Miss Carlson asserts that disclosure of the information required by 18 PA. CONS. STAT. §§3205(a) and 3208 would have provided her with a factual basis for refusing the abortion and finding the means to give birth to her baby, which was her initial and overall desire.

Suzi Dewing became pregnant in 1976, a few months before her wedding date. Her mother, her fiancé, and the doctor who discovered her pregnancy all advised her to have an abortion. She was told nothing about the abortion procedure, any possible adverse consequences, or the development of the unborn child during her pregnancy. It was not until she was on the operating table at the abortion clinic that her doctor asked her, "Would you like me to explain the procedure?" Mrs. Dewing passed out from pain while her cervix was being dilated and never heard the explanation.

The abortion was followed by adverse psychological and physiological consequences for Mrs. Dewing. She felt a desperate need to replace the baby she had aborted. She

moved her wedding day up in order to have another child earlier. However, her two subsequent pregnancies ended with mid-term miscarriages, as did a third pregnancy which followed two successful but complicated pregnancies. These miscarriages were accompanied by feelings of guilt and fear that she was being punished for her abortion.

Mrs. Dewing believes that, had she been informed about the alternatives available to her and the risks and consequences of abortion, her decision would have been different. Specifically, the public and private assistance available for childbirth would have alleviated the insecurity and anxiety of bearing the child without the approval of her family and fiancé. Knowledge of the possibility that an abortion could affect her subsequent childbearing ability would have immediately dissuaded her from having an abortion, because a family was important to her. Likewise, if the development of the unborn child inside her had been explained to Mrs. Dewing, she would not have succumbed to the pressure to abort. In summary, Mrs. Dewing believes that if she had received the information required by 18 PA. CONS. STAT. §§3205(a) and 3208, she would not have chosen to abort.

BRIEF AMICI CURIAE NOTE

The Questions Presented and The Statement of the Case are omitted from this Amici Curiae Brief since they are amply stated in the Appellants' Brief of Richard Thornburgh, et al.

STATUTES INVOLVED

The text of 18 PA. CONS. STAT. §§3205(a)(2) and 3208 is set forth in Appendix A.

SUMMARY OF ARGUMENT

The constitutional right of a woman to choose to terminate her pregnancy includes "at least an equal right to choose to carry her fetus to term as to choose to abort it." *Maier v. Roe*, 432 U.S. 464, 472 n. 7 (1977). The Pennsylvania legislature has a legitimate and compelling interest in protecting the exercise of this fundamental constitutional right to choose by ensuring that any woman exercising the right has the opportunity to be fully informed in making her choice. Toward that end, the legislature enacted 18 PA. CONS. STAT. §§3205(a)(2) and 3208, requiring an abortion practitioner to inform a pregnant woman that medical childbirth assistance benefits may be available to her, that the father is liable for support of the child, and that printed materials are available describing the unborn child and listing agencies offering alternatives to abortion. The information to be disclosed is similar to that held "not objectionable" in *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983).

Because of the contractual, consumer-oriented nature of medical practice in general, and abortion practice in particular, the information supplied by a physician to his patient is a form of "commercial speech" subject to reasonable regulation by the state pursuant to its interest in protecting consumers from deception. The principles recently expounded by this Court in *Zauderer v. Office of Disciplinary Counsel of the Supreme Court of Ohio*, 53 U.S.L.W. 4587 (May 28, 1985) are thus applicable in assessing the constitutionality of Pennsylvania's disclosure requirements. In *Zauderer*, Ohio had required attorneys "to provide somewhat more information than they might otherwise have been inclined to present" in advertising for contingency-fee clients. The disclosure requirement was upheld by this Court because it was not unduly burdensome or intrusive, it did not prescribe unorthodox speech, and it was reasonably related to the state's interest in preventing

consumer deception. Those criteria are met by the Pennsylvania disclosure requirements.

Most significantly, Pennsylvania's regulation of the "commercial speech" attending abortion is entirely consistent with the informed consent doctrine requiring disclosure of relevant facts prior to a patient's decision to undergo treatment. Specifically, the requirements of sections 3205(a)(2) and 3208 reflect Pennsylvania's decision to apply a "patient autonomy" standard of disclosure in all medical practice, including abortion practice. This standard, which has also been adopted by a substantial minority of other states, focuses on the information which a reasonable patient would consider significant in making a decision to undergo medical treatment.

In holding Pennsylvania's disclosure requirements unconstitutional, the court below in effect held that Pennsylvania must adhere to a "physician paternalism" standard of disclosure in the abortion context, as determined by the usual disclosure practices of physicians in similar circumstances. However, if the "patient autonomy" approach is constitutional as applied to medical treatment in general, it should be equally constitutional as applied to abortion. Moreover, "when an issue involves policy choices as sensitive as those implicated [here] . . . , the appropriate forum for their resolution in a democracy is the legislature." *Maier v. Roe*, 432 U.S. at 479.

ARGUMENT

This brief is concerned with the sole issue of whether or not 18 PA. CONS. STAT. §§3205(a)(2)* and 3208 are facially unconstitutional. Your *amici* argue that the Court of Appeals erred in precipitously holding these provisions

*The court below apparently struck down §3205 as a whole, along with §3208, because of its finding of non-severability of those informed consent provisions which it deemed unconstitutional. This brief focuses on the constitutionality of the provisions of §§3205(a)(2) and 3208.

constitutionally infirm in *American College of Obstetricians and Gynecologists v. Thornburgh*, 737 F.2d 283 (3rd Cir. 1984). They concede that the 24-hour waiting period required by section 3205(a)(2) is unconstitutional under *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983), but assert that the waiting period requirement is plainly severable from the remainder of this section.

I. THE INFORMATION TO BE DISCLOSED UNDER SECTION 3205(a)(2) IS "NOT OBJECTIONABLE" UNDER AKRON

As Judge Seitz in dissent observed, the information provided by Section 3205(a)(2) is "similar" to information this Court held "not objectionable" in *Akron. Thornburgh*, 737 F.2d at 313 (Seitz, J., dissenting), quoting *Akron*, 462 U.S. at 445 n. 37. Section 3205(a)(2)(i) and (ii) require that the woman be informed that medical assistance benefits might be available to her if she chooses to carry her child to term, and that the father is economically liable should she choose to do so.

This information on medical assistance benefits and paternal responsibility provided by section 3205(a)(2)(i) and (ii) cannot be fairly said to be sufficiently burdensome or *in terrorem* to cross the line this Court drew between permissible information designed "to inform the woman's consent" and impermissible information designed to "persuade her to withhold it altogether." *Akron* 462 U.S. at 444.

Section 3205(a)(2)(iii) merely requires that the woman be informed of the existence of printed information on abortion alternative agencies and on fetal development, that these materials be provided at the woman's request, and that the woman be assisted in interpreting these materials should she decide that they would be valuable in reaching a decision. It does *not* require the physician or his

agent to recite a "litany of information" regardless of its relevance to the particular patient, as the ordinance at issue in *Akron* would have done. See *Akron*, 462 U.S. at 445. To the contrary, section 3205(a)(2)(iii) initially requires only that the physician or his agent inform the woman of the *availability* of materials on fetal development and abortion alternatives—materials that the woman may choose to inspect or not as she so desires. Moreover, neither the physician nor his agent is required to present the state-produced information as though it represented his own knowledge or views, and indeed they may criticize, comment on, or recommend against inspection of these materials at will.

These provisions are unconstitutional under *Akron*, then, only if one or the other or all contain information that the physician can withhold because he does not believe "the information is relevant to [the woman's] personal decision." *Id.* Knowledge of such information would obviously be relevant to the abortion decisions of at least some women, as the experience of the *amici* attests.

II. AS DISCLOSURE REQUIREMENTS REGULATING COMMERCIAL SPEECH, SECTIONS 3205(a)(2) AND 3208 ARE REASONABLY RELATED TO THE STATE INTEREST IN PREVENTING DECEPTION OF ABORTION CONSUMERS AND IN ASSURING INFORMED CONSENT TO ABORTION

In the highly commercialized and deeply politicized context of abortion practice, it is simply unrealistic to rely on abortion providers to willingly provide information such as that prescribed by section 3205(a)(2) to women contemplating abortion, even though it might be essential to their informed decision making. Indeed, the uncontroverted conclusion of the Pennsylvania legislature, after extensive hearings and debates, is to the contrary:

Reliable and convincing evidence has compelled the General Assembly to conclude and the General Assembly does hereby solemnly declare and find that...[m]any women now seek or are encouraged to undergo abortions without full knowledge of the development of the unborn child or of alternatives to abortion.

18 PA. CONS. STAT. §3202(b)(1). In view of this factual context, and because of the very limited nature of the disclosure requirements of section 3205(a)(2), this Court's recent opinion in *Zauderer v. Office of Disciplinary Counsel of the Supreme Court of Ohio*, 53 U.S.L.W. 4587 (May 28, 1985), is controlling in determining the constitutionality of this provision.

The contractual nature of the physician-patient relationship and the degree to which disclosure requirements have been traditionally imposed on medical practice plainly indicate that the information that physicians provide to patients in order to secure consent to treatment (for which physicians often reap considerable financial rewards) is commercial in nature. Since that information is "commercial speech," it is subject to considerably greater regulation than speech that is not a vehicle of information directly leading to decisions to purchase goods or services. Indeed, because the extension of constitutional protection "to commercial speech is justified principally by the value to consumers of the information speech provides, see *Virginia Pharmacy Board v. Virginia Citizens Consumer Council, Inc.*, 425 U.S. 748 (1976), ...[the] constitutionally protected interest in not providing any particular factual information is minimal." *Zauderer*, 53 U.S.L.W. at 4594 (emphasis in original).

In *Zauderer*, this Court held that the Ohio Supreme Court could properly discipline an attorney for failure to disclose the possible significant litigation costs of an unsuccessful lawsuit in his advertisement seeking clients

for contingency-fee-based suits for damages resulting from use of the Dalkon Shield intrauterine device. Just as in *Zauderer* where "Ohio [had] not attempted to prevent attorneys from conveying information to the public...[but] only required them to provide somewhat more information than they might otherwise have been inclined to present," *Id.* at 4594, Pennsylvania in the instant case does not seek to prevent the physician from presenting his views on abortion or its alternatives, but merely requires that he let his patient know certain additional information that might be critical in arriving at an informed abortion decision and which the physician would not otherwise be inclined to present.

As in *Zauderer*, Pennsylvania has not attempted to prescribe for the physician, his agent, or the woman contemplating abortion "what shall be orthodox in politics, nationalism, religion, or other matters of opinion or force citizens to confess by word or act their faith therein." *Id.*, quoting *West Virginia State Board of Education v. Barnette*, 319 U.S. 624, 642 (1943). The counseling procedure that precedes abortion is certainly analogous to the "counsel" or representations in advertising that an attorney provides to his potential client on the nature and consequences of engaging the attorney to sue, the matter at issue in *Zauderer*; the factual information prescribed by section 3208 is intended to be "objective, non-judgmental and designed to convey only accurate...information." From this perspective, Pennsylvania, like Ohio in *Zauderer*, has "attempted only to prescribe what is orthodox" in the representations made to the woman prior to abortion, which are in the nature of commercial speech or advertising, "and its prescription has taken the form of a requirement that...[abortion practitioners] include...purely factual and noncontroversial information" in their representations to women contemplating abortion. See *Zauderer*, 53 U.S.L.W. at 4594.

As this Court observed in *Zauderer*, “unjustified and unduly burdensome disclosure requirements” might be deemed constitutionally impermissible. *Id.* The detailed and restrictive disclosure requirements imposed by the ordinance at issue in *Akron* might be so characterized, but the requirements of sections 3205(a)(2) and 3208 are far less intrusive and far more permissive. Moreover, like the disclosure requirement upheld in *Zauderer*, the disclosure required by section 3205(a)(2) is reasonably related to the state’s interest in preventing deception of consumers. As the Pennsylvania legislature concluded, women are often deprived of information on abortion alternatives and fetal development when making abortion decisions. 18 PA. CONS. STAT. §3202(b)(1). A requirement that just such information be provided or made available to the woman is thus “reasonably related” to insuring against intentional or negligent deceptive counseling practices that might lead the woman to procure an abortion that she would not have otherwise chosen. It is, therefore, constitutional.

III. CONSIDERING SECTIONS 3205(a)(2) AND 3208 AS REASONABLE DISCLOSURE REQUIREMENTS REGULATING COMMERCIAL SPEECH IS FULLY CONSISTENT WITH THE “INFORMED CONSENT” DOCTRINE AS APPLIED TO OTHER AREAS OF MEDICAL PRACTICE

By enacting sections 3205(a)(2) and 3208, Pennsylvania imposed specific “informed consent” requirements on abortion practice. This legislation hardly represents unique imposition of state authority on the spoken or written disclosures that physicians are generally required to make in order to secure the consent of their patients to medical treatment of all kinds. Both the legislatures and the courts of the several states and the federal government impose disclosure requirements on physicians to assure that full and complete information is provided to patients prior to medical treatment.

Unless abortion is deemed an utterly unique medical procedure, the extent to which the state can properly regulate the “commercial speech” that attends abortion must be determined in the context of the degree to which the state generally imposes disclosure requirements on medical practice. Since providing abortion services is at least as much a commercial enterprise as any other area of medical practice, and since many other areas of medical practice implicate rights and interests of equal or greater import to the individual and the state, it would be anomalous to impose some higher standard on regulation of the “commercial speech” that attends abortion than on regulation of the speech that attends other medical practices. The holding of the Third Circuit presents such an anomaly.

The requirement of section 3205(a)(2) that the physician disclose the availability of medical assistance benefits, enforceability of paternal support, and information on fetal development and abortion alternatives permits the *woman* to decide whether such information is relevant. In striking this provision, the Third Circuit imparts to the physician the privilege to withhold potentially critical information on the theory that the woman has a right to rely on her physician’s “medical judgment” in making a decision that is an exercise of *her* right of privacy. But it is plain that such withholding of information by the physician would have nothing whatever to do with “medical” judgment.

Moreover, the Third Circuit’s opinion neglects entirely the controversy that commentators, courts, and legislators are currently engaged in over what ought to be the standard of disclosure for medical treatment of any kind. Indeed, it would impose on Pennsylvania and several other states a standard of disclosure that is contrary to the standard that their courts and legislature have determined to apply to medical practice generally and with which the requirements of sections 3205(a)(2) and 3208 are fully consistent.

**IV. CONSIDERATION OF THE CONTROVERSY
BETWEEN THE "PHYSICIAN PATERNALISM"
AND THE "PATIENT AUTONOMY"
APPROACHES TO INFORMED CONSENT IS
CRITICAL TO EVALUATING THE
PERMISSIBLE SCOPE OF GOVERNMENTAL
REGULATION OF THIS FORM OF
COMMERCIAL SPEECH**

The debate over what standard ought to govern disclosures the physician must make to his patient in order to receive informed consent concerns two competing perspectives.

One perspective, which emphasizes physician discretion and judgment, may be called the "physician paternalism" approach. Its proponents say that the standard of disclosure ought to be that practiced by physicians in the locality. This approach, like that taken by the Third Circuit in this case, assumes that doctors generally know what is best for their patients, and gives doctors, as a group, great leeway to circumscribe the breadth and scope of the information to be disclosed to or withheld from the patient.

The other perspective, which emphasizes patient knowledge and decision, may be called the "patient autonomy" approach. Its proponents say that the standard of disclosure ought to be what an average, reasonable patient would consider material to the decision, regardless of what physician practice may be. This approach assumes that competent adults should be enabled to determine for themselves what is done with their bodies, and places the premium on patient freedom of choice.

Pennsylvania law clearly follows the "patient autonomy" approach to informed consent to medical treatment. *Jeffries v. McCague*, 242 Pa. Super. 76, 362 A.2d 1167 (1976); *Bowers v. Garfield*, 382 F. Supp. 503 (E.D. Pa. 1974); *Copper v. Roberts*, 220 Pa. Super. 260, 286 A.2d 647 (1971); *Gray v. Grunnagle*, 423 Pa. 144, 223 A.2d 663 (1966).

Indeed, failure to secure informed consent is considered an intentional tort ("a technical assault") in Pennsylvania, rather than an expression of negligence. *See, e.g., Jeffries*, 363 A.2d at 1171.

At the same time, informed consent to medical treatment is deemed to be "an area basically governed by contractual concepts." *Copper*, 286 A.2d at 650. The consumer-oriented, contractual approach to informed consent demands that, because "the patient must bear the expense, pain and suffering of any injury from the . . . treatment, his right to know all the material facts pertaining to the proposed treatment cannot be dependent upon the self-imposed standard of the medical profession." *Id.* Thus, the medical profession's "community of silence" is not permitted to deny the patient any material facts needed to make an informed decision under Pennsylvania law.

Pennsylvania clearly follows this same approach with regard to abortion. The legislature chose not to defer to the abortion-performing physician's view of what is best and allow him or her to control the flow of information to the patient, as under the "physician paternalism" approach. Rather, the legislature proceeded on the assumption that abortion is an especially personal decision, to be made by the woman herself, and sought to assure her of access to the information material to that decision, thus employing the rationale behind the "patient autonomy" approach.

Without any discussion of the arguments which have been advanced for and against each approach, or of the relation of constitutional provisions to those arguments, the Third Circuit, in striking sections 3205(a)(2) and 3208, in effect held that, at least in the context of abortion, the Constitution imposes on the States the "physician paternalism" option and forbids to them the "patient autonomy" approach. The ruling prohibits the state from regulating the "commercial speech" that attends abortion by applying as the standard of disclosure what the average,

responsible abortion patient might want to know in order to make a competent abortion decision. Instead, according to the Third Circuit, the physician, as a matter of constitutional law, has a right to withhold information from the abortion patient if abortion practitioners customarily do so. In view of Pennsylvania's strong adherence to the doctrine of "patient autonomy," this holding creates an anomaly in Pennsylvania law: abortion practitioners may operate on an altogether different standard of disclosure than physicians in all other circumstances.

In the belief that no final ruling on the application of the Constitution to informed consent requirements for abortion should be made without at least some consideration of the nature of informed consent requirements for medical treatment in general, your *amici* offer the remainder of this brief for the limited purpose of reviewing the two competing approaches to informed consent disclosure standards and the relevance of those approaches to the validity of legislative judgments about what standard best achieves effective freedom of choice for women deciding whether to undergo abortion.

We address what should be a central issue in this case: whether, in light of the considerable controversy over the respective wisdom of the "physician paternalism" and "patient autonomy" approaches, this Court should adopt a rule that constitutionally freezes the "physician paternalism" approach as the only allowable model for abortion related informed consent legislation, or whether, "when an issue involves policy choices as sensitive as those implicated [here] . . . , the appropriate forum for their resolution in a democracy is the legislature." *Maher v. Roe*, 432 U.S. 464, 479 (1977).

Pennsylvania's treatment of the "commercial speech" that attends abortion is fully consistent with the "patient autonomy" approach it takes toward informed consent to

all other medical procedures. This Court should not carve out a special doctrine for the commercial speech attending abortion that is contrary to the expressed preference of Pennsylvania and several states for patient autonomy, as well as to this Court's holding in *Zauderer* that the State may constitutionally require disclosure of potentially critical information in a similar commercial setting.

A. Medical Treatment Requires the Consent of the Patient, and the Universal Modern Rule Is That the Consent Must Be Informed

Under Anglo-American law, it is axiomatic that a physician must first obtain the patient's consent before undertaking any non-emergency treatment. As Justice Cardozo stated in *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 129-130, 105 N.E. 92, 93 (1914):

Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable in damages.

As the consent doctrine evolved, it became necessary under the law for the physician not only to obtain permission to proceed, but also to make a reasonable disclosure to the patient of the nature and probable consequences of the proposed treatment. See *Salgo v. Stanford University Bd. of Trustees*, 154 Cal. App.2d 560, 317 P.2d 170 (1957), the landmark case introducing the principle. "Numerous courts throughout the 1960's looked beyond the fact of the patient's consent to question the quality of the physician's disclosure underlying the consent." A ROSOFF, INFORMED CONSENT 4 (1981). Some version of the informed consent requirement is now in effect in all but one of the United States. See Table of Current Positions on the Approach to Informed Consent by State, this brief at 22.

B. The Older "Physician Paternalism" Approach Has Been Replaced by the Newer "Patient Autonomy" Approach in Pennsylvania and a Substantial Number of Other States

When the informed consent doctrine first came to be applied in the late 1950's and early 1960's, it was initially analyzed in the manner of traditional medical malpractice tort negligence. Like the duty of care by which deviations amounting to negligence are measured, the duty of disclosure by which deviations amounting to denial of informed consent were to be measured was set as "those disclosures which a reasonable medical practitioner would make under the same or similar circumstances." *Natanson v. Kline*, 186 Kan. 393, 409-10, 350 P.2d 1093, 1106 (1960). This approach came to mean that a physician need only disclose those facts which the average, reasonable practitioner, of the same speciality and geographic location, would have revealed under similar circumstances. Victor, *Informed Consent*, 1981 MEDICAL TRIAL TECH. 138, 146. See, e.g., *Woolley v. Henderson*, 418 A.2d 1123, 1128-32 (Me. 1980).

Courts first began to move away from this approach in dealing with elective surgery—a category into which most abortions fall. For example, in *Scott v. Wilson*, 396 S.W.2d 532 (Tex. Civ. App. 1965), *aff'd sub nom. Wilson v. Scott*, 412 S.W.2d 299 (Tex. 1967), the court held that when a patient is considering an elective operation, a physician has the duty to make a full disclosure of the nature of the operation, the process contemplated, the dangers of the operation and possible alternatives to the treatment.

The full introduction of the "patient autonomy" approach into case law came in *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972), which remains the leading case. The D.C. Circuit concluded that "[r]espect for the patient's right of self-determination on particular therapy demands a standard set by law for

physicians rather than one which physicians may or may not impose upon themselves." *Id.* at 780. It based its decision on the premise that "it is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests lie," and that the duty to disclose information important for that determination is not "dependent upon the existence and nonperformance of a relevant professional tradition." *Id.* at 777, 779.

Instead of usual professional practice, therefore, the court concluded:

[T]he patient's right of self-decision shapes the boundaries of the duty to reveal. That right can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The scope of the physician's communications to the patient, then, must be measured by the patient's need, and that need is the information material to the decision. Thus the test for determining whether a particular peril must be divulged is its materiality to the patient's decision.

Id. at 782-83.

The *Canterbury v. Spence* "patient autonomy" approach came to be followed by a substantial minority of jurisdictions. Adopting the position, a Maryland court summarized the trend:

In recent years...an ever-expanding number of courts have declined to apply a professional standard of care in informed consent cases, employing instead a general or lay standard of reasonableness set by law and independent of medical custom. These decisions recognize that protection of the patient's fundamental right of physical self-determination—the very cornerstone of the informed consent doctrine—mandates that the scope of a physician's duty to disclose...be governed by the patient's informational needs. Thus, the appropriate test is not what the physician in the exercise of his medical judgment

thinks a patient should know before acquiescing in a proposed course of treatment; rather, the focus is on what data the patient requires in order to make an intelligent decision.

Sard v. Hardy, 281 Md. 432, 442, 379 A.2d 1014, 1021 (1977). See also Victor, *supra* p. 20, at 148; Seidelson, *Medical Malpractice: Informed Consent Cases in "Full Disclosure" Jurisdictions*, 14 DUQ. L. REV. 309, 312 (1976).

The following table summarizes the 1985 positions on standards of disclosure of the District of Columbia, Puerto Rico, and the 50 states. Twenty-eight of the jurisdictions with positions adopt an approach differing from the pure "physician paternalism" model which the Third Circuit implicitly held to be the only approach the Constitution accepts when applied to "commercial speech" attending abortion. Pennsylvania strongly insists on application of the patient autonomy rule. See this brief at 16. The newer "patient autonomy" approach, therefore, is seen to be an approach accepted and advocated by a substantial minority of states for reasons closely related to the essential basis of the informed consent doctrine. This understanding counsels against pre-empting Pennsylvania's legislative choice through the establishment of a constitutional rule compelling "physician paternalism."

**TABLE OF CURRENT POSITIONS ON THE
APPROACH TO INFORMED CONSENT BY
STATE***

State	No Law	Patient Autonomy	Physician Paternalism	Hybrid
Alabama ¹			X	
Alaska ²				X
Arizona ³			X	
Arkansas ⁴			X	
California ⁵				X
Colorado ⁶			X	
Connecticut ⁷		X		
Delaware ⁸			X	
District of Columbia ⁹		X		

Florida ¹⁰				X
Georgia ¹¹		X		
Hawaii ¹²		X		
Idaho ¹³				X
Illinois ¹⁴		X		
Indiana ¹⁵				X
Iowa ¹⁶				X
Kansas ¹⁷		X		
Kentucky ¹⁸				X
Louisiana ¹⁹	X			
Maine ²⁰		X		
Maryland ²¹	X			
Massachusetts ²²				X
Michigan ²³		X		
Minnesota ²⁴	X			
Mississippi ²⁵		X		
Missouri ²⁶		X		
Montana ²⁷		X		
Nebraska ²⁸		X		
Nevada ²⁹				X
New Hampshire ³⁰		X		
New Jersey ³¹		X		
New Mexico ³²	X			
New York ³³		X		
North Carolina ³⁴				X
North Dakota ³⁵				X
Ohio ³⁶	X			
Oklahoma ³⁷	X			
Oregon ³⁸	X			
Pennsylvania ³⁹	X			
Puerto Rico ⁴⁰		X		
Rhode Island ⁴¹	X			
South Carolina ⁴²		X		
South Dakota ⁴³	X			
Tennessee ⁴⁴		X		
Texas ⁴⁵	X			
Utah ⁴⁶		X		
Vermont ⁴⁷				X
Virginia ⁴⁸		X		
Washington ⁴⁹	X			
West Virginia ⁵⁰	X			
Wisconsin ⁵¹	X			
Wyoming ⁵²		X		
TOTAL	1	15	24	12

*The sources for this summary are given by state in Appendix B.

C. Sections 3205(a)(2) and 3208 Apply the "Patient Autonomy" Approach to Abortion

Sections 3205(a)(2) and 3208 provide for disclosure concerning the availability of medical assistance benefits, paternal support, and printed information on abortion alternatives and fetal development. It was logical for Pennsylvania to consider these categories to be material to the decision whether or not to undergo an abortion. Since materiality to the decision is the standard for disclosure employed by states such as Pennsylvania which have adopted the "patient autonomy" approach, disclosure with regard to these categories lies fully within the bounds of informed consent doctrine.

Over the 20-odd years since the term informed consent came into usage in the medicolegal context, courts have been developing, on a case-by-case basis, a list of items requiring disclosure. Stated in simple, generic terms, the list includes:

- * diagnosis (i.e., the patient's condition or problem)
- * nature and purpose of the proposed treatment
- * risks and consequences of the proposed treatment
- * probability that the proposed treatment will be successful
- * feasible treatment alternatives
- * prognosis if the proposed treatment is not given.

ROSOFF, *supra* p. 19, at 41 (emphasis in original).

The disclosures required by sections 3205(a)(2) and 3208 fit within these categories. Disclosure of medical assistance benefits, paternal support, and the availability of printed information on abortion alternatives plainly relates to "feasible treatment alternatives"—the nature of the financial and other support the woman might have available should she choose to carry her child to term rather than to abort. So long as the "patient autonomy"

approach is accepted as a constitutionally available alternative to the "physician paternalism" approach, "commercial speech" disclosure requirements in these categories can hardly be objectionable.

It has been suggested, however, that disclosure of information concerning the characteristics of the fetus, such as that made available under sections 3205(a)(2) and 3208, "is not directly material to any medically relevant fact, and thus does not serve the concern for providing adequate medical information that lies at the heart of the informed consent requirement." *Planned Parenthood League of Massachusetts v. Bellotti*, 641 F.2d 1006, 1021 (1st Cir. 1981). This perception misconceives both the nature of the standard of disclosure in informed consent doctrine—at least under the "patient autonomy" approach—and the meaning of "medically relevant" in the context of abortion as that concept has been delineated by this Court.

"[T]he very basis of the informed consent theory [is] the patient's right to be the final judge to do with his body as he wills." *Wilkinson v. Vesey*, 110 R.I. 606, 625, 295 A.2d 676, 688 (1972). Central to this position is the view that the "decision about what is or is not relevant information upon which a patient can base an informed consent is a human judgment, not a determination requiring medical expertise." Note, *Restructuring Informed Consent: Legal Therapy for the Doctor-Patient Relationship*, 79 YALE L.J. 1533 (1970). Accord, *Wilkinson*, 295 A.2d at 688. From the "patient autonomy" perspective, therefore, the nature of the information deemed material to the patient's decision is not inherently limited to a description only of physical health risks associated with the procedure; rather, the question of materiality is, as a Washington court phrased it, "Would the patient as a human being consider this item in choosing his or her course of treatment?" *Miller v. Kennedy*, 11 Wash. App. 272, 282-283, 522 P.2d 852, 860 (1974). *aff'd*, 85 Wash.2d 151, 530 P.2d 334 (1975).

It is simply disingenuous to argue that information about the fetus is irrelevant to a choice about abortion, and that the only things "the patient as a human being [would] consider" in making a reflected choice whether to undergo it are physical health risks. As this Court noted in *Roe v. Wade*, 410 U.S. 113, 116 (1973), "One's philosophy, one's experiences, one's exposure to the raw edges of human existence, ...one's attitudes toward life and family and their values, and the moral standards one establishes and seeks to observe, are all likely to influence and to color one's thinking and conclusions about abortion." That network of values revolves around the attitude one takes toward the fetus's status and prospects as weighed together with the needs and plans of the pregnant woman and perhaps her family. If, as Laurence Tribe has suggested, "*Roe v. Wade* represents less a decision in favor of abortion than a decision in favor of leaving the matter, however it might come out in particular cases, to women..." L. TRIBE, *AMERICAN CONSTITUTIONAL LAW* 933 (1978), then it cannot properly be said that the whole tangle of ethical and human issues inherently associated with abortion are to be deemed irrelevant to women's decisionmaking. Those issues are inextricably bound up with the existence and nature of the fetus.

Thus, the notion that information on fetal development is "medically irrelevant" is mechanistically narrow in a manner at odds with this Court's delineation of that concept in the context of abortion. "[M]edical judgment," this Court has held, "may be exercised in the light of all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the wellbeing of the patient. All these factors may relate to health." *Doe v. Bolton*, 410 U.S. 179, 192 (1973). This sense of the medically relevant is certainly broader than merely physical complications; it argues against the exclusion of fetal information from the realm of the "medical."

The applicability of the "patient autonomy" informed consent rationale is not diminished because information about the fetus has no precise analogue in information required to be disclosed about other medical procedures. "The simple answer to the argument that similar requirements are not imposed for other medical procedures is that such procedures do not involve the termination of a potential human life." *Maher v. Roe*, 432 U.S. at 480. The essential point is that the rationale for the disclosure of fetal information is the same as that for the disclosure of information associated with medical treatments other than abortion: in the "patient autonomy" view, disclosure should be made of "what the patient would consider important to [her] decision." *Canterbury v. Spence*, 464 F.2d at 783.

The requirement of section 3205(a)(2)(iii) merely permits the woman to decide whether *she* considers the information on fetal development important enough to her decision to view it. Only a most paternalistic view of the abortion decision—a view otherwise forthrightly and uniformly rejected by Pennsylvania—would presume to deny the woman the right to know that such materials even exist.

In sum, the disclosures required by sections 3205(a)(2) and 3208 are rooted in the philosophy that underlies the "patient autonomy" approach to informed consent used by a respectable minority of the States, including Pennsylvania: "The patient has the right to chart [her] own destiny, and the doctor must supply the patient with the material facts the patient will need in order to intelligently chart that destiny with dignity." *Miller v. Kennedy*, 522 P.2d at 860. The requirement to disclose information about medical assistance benefits, paternal support, and the existence of materials on alternatives to abortion and the characteristics of the fetus is medically relevant and fits appropriately into the "patient autonomy" informed consent doctrine.

D. From a "Patient Autonomy" Perspective, There is Ample Precedent and Reason for Providing No "Therapeutic Exception" in Section 3205(a)(2)

Section 3205(a)(2) requires disclosure in all non-emergency instances. It thus parts company with the rule in some "patient autonomy" jurisdictions—significantly, not in Pennsylvania*—which holds that a physician has a limited privilege not to disclose information to a patient for "therapeutic" reasons. The privilege is an exception to the general duty of disclosure, and is not recognized by several states. This exception, where it is recognized, is meant to deal with occasions when disclosure would risk making a patient "so ill or emotionally distraught... as to foreclose a rational decision, or complicate or hinder the treatment, or perhaps even pose psychological damage to the patient." *Canterbury v. Spence*, 464 F.2d at 786. The *Canterbury* court itself warned, however, that the therapeutic exception

must be carefully circumscribed...for otherwise it might devour the disclosure rule itself. The privilege does not accept the paternalistic notion that the physician may remain silent simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs. That attitude presumes instability or perversity even for the normal patient, and runs counter to the foundation principle that the patient should and ordinarily can make the choice for himself.

**Bulman v. Myers*, 467 A.2d 1355 (Pa. Super. 1983); *Sauso v. Shea*, 390 A.2d 259 (Pa. Super. 1978); *Dunham v. Wright*, 423 F.2d 940 (3rd Cir. 1970). 40 PA. CONS. STAT. §1301.103 (1982) added a therapeutic privilege exception to a Pennsylvania malpractice act, but most of this law was struck down in *Mattos v. Thompson*, 491 Pa. 385, 421 A.2d 190 (1980), as an unconstitutional infringement on the right to a jury trial. The therapeutic exception was untouched by this, but was to be used for the purpose of the gutted act and has not been invoked by any court as grounds for finding a general therapeutic exception in Pennsylvania law.

Id. The court concluded that the privilege to withhold disclosure should operate only when the physician reasonably foresees that the patient's reaction will be "menacing." *Id.*

Indeed, a number of states which employ or have elements of the "patient autonomy" approach have failed to recognize a "therapeutic exception." Pennsylvania is among them. (The others are Connecticut, Florida, Kentucky, Nevada, New Mexico, Ohio, and Rhode Island.) See Meisel & Kabnick, *Informed Consent to Medical Treatment: An Analysis of Recent Legislation*, 41 U. PITT L. REV. 407, 457 (1980); *Dunham v. Wright*, 423 F.2d 940, 944-45 (3rd Cir. 1970) (construing Pennsylvania law); *Logan v. Greenwich Hospital Assoc.*, 465 A.2d 274 (Conn. 1983) (therapeutic privilege mentioned but not passed upon); *Henning v. Parsons*, 95 N.M. 454, 623 P.2d 574 (1981) (no mention of therapeutic privilege); *Congrove v. Holmes*, 37 Ohio Misc. 95, 308 N.E.2d 765 (Comm. Pleas 1973) (No mention of therapeutic privilege); *Beauvais v. Notre Dame Hospital*, 387 A.2d 689 (R.I. 1978) (no mention of therapeutic privilege).

Reluctance of states to reintroduce "physician paternalism" by way of a therapeutic exception is well-founded. "Available evidence indicates that the physician's decisions to withhold information are based on hearsay rather than on actual experience with the effects of full disclosure and that the physician's own emotional reluctance to confront the patient with stark diagnoses and risks often prevents disclosure." Note, *Restructuring Informed Consent*, *supra* p. 25. Professor Simpson of Northwestern University Law School states that the traditional pessimism of courts over the ability of patients to make rational decisions about their medical treatment is based on "myth" and conjecture. Simpson, *Informed Consent: From Disclosure to Patient Participation in Medical Decisionmaking*, 76 N.U.L. REV. 172, 178 (1981). "It appears that the possibility of adverse effects arising from disclosure has been overstated," asserts Simpson.

Studies show that the large majority of patients do not refuse treatment after being informed about "relatively risky medical procedures," that they withstand surgery better than uninformed patients and that, on the average, informed patients "suffer equal or lower levels of anxiety" than patients who are not informed. *Id.* at 180.

In the abortion context, the psychological harm to the patient assertedly associated with disclosure of information about the fetus, see *Planned Parenthood League of Massachusetts v. Bellotti*, 641 F.2d at 1021; *Planned Parenthood Association of Kansas City, Mo. v. Ashcroft*, 655 F.2d 848, 868 (8th Cir. 1981); *Charles v. Carey*, 627 F.2d 772, 784 (7th Cir. 1980), may be experienced far more severely after the procedure has been irrevocably performed if the patient later learns about the information withheld from her. Common sense suggests that the very women who are most likely to be upset by disclosures before the abortion, and thus those most likely to be candidates for the therapeutic exception, are the ones most likely to experience psychological complications after the abortion upon learning the information withheld. Furthermore, they are precisely the women whose choice would most likely be different if fully informed, and thus those most likely to be deprived of a truly autonomous choice by the paternalistic decision not to disclose.

In the present context, it is impossible to see how information on medical assistance benefits, paternal support, or the existence of abortion alternatives could possibly warrant invocation of a therapeutic exception, even if such an exception generally existed in Pennsylvania law. Since the information on fetal development, which is only provided to the woman *if she requests it*, must be "scientifically accurate" and "nonjudgmental" under section 3208, it cannot be assumed as a matter of law that the printed information will be of a nature that will "foreclose rational decision," "hinder treatment," or "pose psychological damage." *Canterbury v. Spence*, 464 F.2d at 785.

Surely it should be within the legislature's discretion to decide whether, in a particular context, the adoption of a therapeutic exception enhances or harms informed consent based on the "patient autonomy" approach. The decision of the Pennsylvania legislature not to include such an exception in the Pennsylvania statute must be regarded as embodying a position grounded in precedent, properly responsive to the particular circumstances of abortion, and supported by respectable opinion in scholarly debate.

CONCLUSION

In *Akron*, this Court held that regulations on the speech that attends abortion must be designed to "inform the woman's consent" rather than "to persuade her to withhold it altogether" in order to escape the charge that such regulations are unjustified and unduly burdensome. *Akron*, 462 U.S. at 444; cf. *Zauderer*, 53 U.S.L.W. at 4594. Under this standard, sections 3205(a)(2) and 3208 should not be declared facially unconstitutional, as the Third Circuit did. Rather, a finder of fact should determine whether these provisions, and the printed materials they incorporate, would provide valuable information to women contemplating abortion or would merely confuse and confound their decisions. It is simply not evident on the face of these provisions that their requirements are unjustified or unduly burdensome, as the Third Circuit held they were. Because this case was decided upon appeal of the District Court's action on a preliminary injunction, there was no full trial on the merits to permit the development of facts necessary to determine whether or not these provisions are unconstitutional in their actual application.

Your *amici* therefore argue that, because these provisions are not facially unconstitutional, this Court should remand to the District Court with instructions to determine whether section 3205(a)(2) and the printed information produced pursuant to section 3208 represent,

in their actual application, unjustified or unduly burdensome impositions on the rights of the women contemplating abortion under the standards of *Akron* and *Zauderer*.

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APPENDICES

APPENDIX A

18 PA. CONS. STAT. §3205(a)(2) (1983):

§3205. Informed consent

(a) General rule.—No abortion shall be performed or induced except with the voluntary and informed consent of the woman upon whom the abortion is to be performed or induced. Except in the case of a medical emergency, consent to an abortion is voluntary and informed if and only if....

(2) The woman is informed, by the physician or his agent, at least 24 hours before the abortion:

(i) The fact that medical assistance benefits may be available for prenatal care, childbirth and neonatal care.

(ii) The fact that the father is liable to assist in the support of her child, even in instances where the father has offered to pay for the abortion.

(iii) That she has the right to review the printed materials described in section 3208 (relating to printed information). The physician or his agent shall orally inform the woman that the materials describe the unborn child and list agencies which offer alternatives to abortion. If the woman chooses to view the materials, copies of them shall be furnished to her. If the woman is unable to read the materials furnished her, the materials shall be read to her. If the woman seeks answers to questions concerning any of the information or materials, answers shall be provided her in her own language.

18 PA. CONS. STAT. §3208 (1983):

§3208. Printed information

(a) General Rule.—The department shall cause to be published in English, Spanish and Vietnamese, within 60 days after this chapter becomes law, the following easily comprehensible printed materials:

(1) Geographically indexed materials designed to inform the woman of public and private agencies and services available to assist a woman through pregnancy, upon childbirth and while the child is dependent, including adoption agencies, which shall include a comprehensive list of the agencies available, a description of the services they offer and a description of the manner, including telephone numbers, in which they might be contacted, or, at the option of the department, printed materials including a toll-free 24-hour a day telephone number which may be called to obtain, orally, such a list and description of agencies in the locality of the caller and of the services they offer. The materials shall include the following statement:

"There are many public and private agencies willing and able to help you to carry your child to term, and to assist you and your child after your child is born, whether you choose to keep your child or to place her or him for adoption. The Commonwealth of Pennsylvania strongly urges you to contact them before making a final decision about abortion. The law requires that your physician or his agent give you the opportunity to call agencies like these before you undergo an abortion."

(2) Materials designed to inform the woman of the probable anatomical and physiological characteristics of the unborn child at two-week gestational increments from fertilization to full

term, including any relevant information on the possibility of the unborn child's survival. The materials shall be objective, nonjudgmental and designed to convey only accurate scientific information about the unborn child at the various gestational ages.

(b) Format.—The materials shall be printed in a typeface large enough to be clearly legible.

(c) Free distribution.—The materials required under this section shall be available at no cost from the department upon request and in appropriate number to any person, facility or hospital.

APPENDIX B
NOTES TO TABLE OF CURRENT POSITIONS ON
THE APPROACH TO INFORMED CONSENT BY
STATE

¹ALABAMA. *Roberts v. Wood*, 206 F. Supp. 579 (S.D. Ala. 1962).

²ALASKA. *Poulin v. Zoitman*, 542 P.2d 251 (Alaska 1975); *Patrick v. Sedwick*, 391 P.2d 453 (Alaska 1964); ALASKA STAT. §09.55.556 (Supp. 1983). The common law standard of disclosure is not adequately articulated in these two cases. However, the statute requires that a physician disclose common risks and reasonable alternatives to the proposed treatment. The health care provider may limit the extent of the information disclosed if he reasonably believes that a full disclosure would have an adverse effect on the patient's condition.

³ARIZONA. *Shetter v. Rochelle*, 2 Ariz. App. 358, 409 P.2d 74 (Ct. App. 1965). Note, however, that even though Arizona follows a "physician paternalism" rule, the court said that the consentor must understand substantially the nature of the surgical procedure attempted and the probable results of the operation. See also, *Riedisser v. Nelson*, 534 P.2d 1052, 111 Ariz. 542 (1975); *Rodriguez v. Jackson*, 574 P.2d 481, 118 Ariz. 13 (1977); *Hales v. Pittman*, 576 P.2d 493, 118 Ariz. 305 (1978). Under *Hales*, the scope of disclosure required can be expanded by the patient's instructions to the doctor and information may not be withheld if it is relevant to the patient's ability to give his or her informed consent.

⁴ARKANSAS. *Pegram v. Sisco*, 406 F.Supp. 776 (W.D. Ark. 1976); *Fuller v. Starnes*, 597 S.W.2d 88, 268 Ark. 476 (1980); ARK. STAT. §34-2614.

⁵CALIFORNIA. *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1,

104 Cal. Rptr. 505 (1972). California applies the "patient autonomy" approach with respect to any potential of death or serious harm; beyond such risks, disclosure is required according to the "physician paternalism" rule. See also *McKinney v. Nash*, 120 Cal. App. 3d 428, 174 Cal. Rptr. 642 (1981); *Nelson v. Gaunt*, 125 Cal. App. 3d 623, 178 Cal. Rptr. 167 (1981). CAL. HEALTH AND SAFETY CODE §1704.5 (1980) requires doctors to inform patients with breast cancer of risks and alternative treatments. CAL. BUSINESS AND PROFESSIONAL CODE §4211.5 provides for patient autonomy in DMSO treatments.

⁹COLORADO. *Mallett v. Pirkey*, 171 Colo. 271, 466 P.2d 466 (1970). Though the rule in Colorado falls under a "physician paternalism" model, the burden rests upon the doctor to prove, if challenged, that his behavior conformed to acceptable standard physician practice. See also *Greenwell v. Gill*, 660 P.2d 1305 (Colo. App. 1982); *Blaskas v. Murray*, 646 P.2d 907 (Colo. 1982) cites the rule in *Mallett* but links the duty to disclose to the level of risk the patient is exposed to. If the doctor knew or should have known that risk would be a significant factor in the patient's decision, he must disclose.

¹⁰CONNECTICUT. *Logan v. Greenwich Hospital Association*, 465 A.2d 294 (Conn. 1983). Connecticut adopted a patient autonomy rule in this case, without passing upon the therapeutic exception.

¹¹DELAWARE. *Coleman v. Garrison*, 349 A.2d 8 (Del. 1975); DEL. CODE ANN. tit. 18, §§6851-6852 (Supp. 1984). See also *Robinson v. Mroz*, 433 A.2d 1051 (Del. Super. Ct. 1981). DEL. CODE ANN. tit. 24 §1794 (Rev. 1974) adopts a patient autonomy rule for abortion.

¹²DISTRICT OF COLUMBIA. *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972). See also *Crain v. Allison*, 443 A.2d 558 (D.C. App. 1982); *Hartke v. McKelway*, 707 F.2d 1544 (D.C. Cir. 1983).

¹³FLORIDA. *Ditlow v. Kaplan*, 181 So. 2d 226 (Fla. Dist.

Ct. App. 1965); *Bowers v. Talmadge*, 159 So. 2d 888 (Fla. Dist. Ct. App. 1964); FLA. STAT. ANN. §768.45 (West Supp. 1985). Under the Florida statute, a physician may disclose information in accordance with accepted medical practice, but that degree of disclosure must be sufficient to permit a reasonable individual to have a general understanding of the procedure, acceptable alternative treatments, and any substantial risks and hazards recognized as inherent in the procedure. Accord *Bowers v. Talmadge*, but *Ditlow v. Kaplan* holds that a doctor who advises a patient that a procedure is serious and "risky" should be discharged unless the plaintiff presents expert testimony that it is the custom to volunteer more detailed information. See also *Ritz v. Florida Patient's Compensation Fund*, 436 So. 2d 987 (Fla. Dist. Ct. App. 1983); *Thomas v. Berrios*, 348 So. 2d 905 (Fla. Dist. Ct. App. 1977).

¹⁴GEORGIA. *Young v. Yarn*, 136 Ga. App. 737, 222 S.E.2d 113 (Ct. App. 1975); GA. CODE ANN. §§88-2901 to -2907 (1981); not applicable to abortion and sterilization. See also *Padgett v. Ferrier*, 323 S.E. 2d 166 (Ga. App. 1984); *Hyles v. Cockrill*, 312 S.E.2d 124, 169 Ga. App. 132 (1983); *Charles v. State*, 307 S.E.2d 701, 167 Ga. App. 803 (1983).

¹⁵HAWAII. *Nishi v. Hartwell*, 52 Hawaii 188, 473 P.2d 116 (1970); HAWAII REV. STAT. §§671-3 (1976). The statute fails to specify the standard by which the adequacy of the physician's disclosure is to be measured. The statute empowers the state board of medical examiners to establish these standards. *Nishi* appears to apply a "physician paternalism" standard. Nevertheless, there is language in the opinion which suggests that the court is adhering to a "full-disclosure" patient-autonomy rule with the therapeutic exception.

¹⁶IDAHO. *LePelly v. Grefenson*, 101 Idaho 422, 614 P.2d 762 (1980); IDAHO CODE §18-609 (Supp. 1984), §§39-4301 to -4306 (1977). Under *LePelly*, though the "physician paternalism" rule is adopted, the court held that when relatively complicated surgery is involved a physician

must disclose known risks of death or serious bodily injury. Although §§39-4301 to -4306 adopt a "physician paternalism" approach, they do not apply to abortion procedures. A "patient autonomy" approach to abortion is provided in §18-609.

¹⁴ILLINOIS. *Green v. Hussey*, 127 Ill. App. 2d 174, 263 N.E.2d 156 (App. Ct. 1970); ILL. REV. STAT. ch. 38, §81-23.2 (1981). Though *Green* adopts the "physician paternalism" rule, Illinois statutory law adopts the "patient autonomy" approach for abortion procedures. See also *Magana v. Elie*, 439 N.E.2d 1319, 108 Ill. App. 3d 1028, 64 Ill. Dec. 511 (1982); *Guebard v. Jabaay*, 452 N.E.2d 751, 117 Ill. App. 3d 1, 72 Ill. Dec. 498. (1983).

¹⁵INDIANA. *Joy v. Chau*, 377 N.E.2d 670 (Ind. Ct. App. 1978). The *Joy* court held that a physician is to make a reasonable disclosure to his patient, but failed to adopt either of the two rules. See also *Revord v. Russell*, 401 N.E.2d 763 (Ind. App. 1980); *Kranda v. Houser-Norborg Medical Corp.*, 419 N.E.2d 1024 (Ind. App. 1981).

¹⁶IOWA. *Grosjean v. Spencer*, 258 Iowa 685, 140 N.W.2d 139 (1966); IOWA CODE ANN. §147.137 (West Supp. 1982-83). Prior to the adoption of the statute, Iowa followed the "physician paternalism" rule. Though the statute cannot be classified as following either of the two rules, it does require the physician to disclose the nature and purpose of the proposed treatment and the known risks if they are included in a specified list of serious dangers. See also *Cowman v. Hornaday*, 329 N.W.2d 422 (Iowa 1983). The court held the "professional rule" inapplicable in this case and applied the "patient rule." *Cowman* involved elective surgery—"a vasectomy for socioeconomic reasons."

¹⁷KANSAS. *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093 (1960); *Lindquist v. Ayerst Laboratories, Inc.*, 607 P.2d 1339, 227 Kan. 308 (1980).

¹⁸KENTUCKY. *Holton v. Pfingst*, 534 S.W.2d 786 (Ky. 1975); *Bennett v. Graves*, 557 S.W.2d 893 (Ky. Ct. App.

1977); KY. REV. STAT. ANN. §§304.40-320 (Baldwin 1981). *Bennett* and *Holton* adopt the "physician paternalism" rule. However, the statutory provisions adopted after *Holton* require that information be provided to the patient such that "a reasonable individual...would have a general understanding of the procedure and...acceptable alternative procedures...and substantial risks and hazards inherent in the proposed treatment..." See also KY. REV. STAT. §§311.726, 311.729 (1983) (informed consent statute for abortion requiring physician to divulge information on risks, fetal development, and alternatives.)

¹⁹LOUISIANA. *Percle v. St. Paul Fire and Marine Ins. Co.*, 349 So. 2d 1289 (La. Ct. App. 1977); LA. REV. STAT. ANN. §40:1299.40 (West 1977). See also *LaCaze v. Collier*, 434 So. 2d 1039 (La. 1983), which applies the patient autonomy standard of LA. REV. STAT. ANN. §40:1299.40 (West 1977). A measure of patient autonomy applies to abortion as well under LA. REV. STAT. §40:1299.35.6 (1977).

²⁰MAINE. *Woolley v. Henderson*, 418 A.2d 1123 (Me. 1980); ME. REV. STAT. ANN. tit. 24, §2905 (Supp. 1984-1985). Maine has an informed consent statute for abortion requiring the physician to inform the patient of the nature of the procedure, gestational age, risks, and alternatives. ME. REV. STAT. ANN. tit. 22 §1599 (1984-1985).

²¹MARYLAND. *Sard v. Hardy*, 281 Md. 432, 379 A.2d 1014 (Ct. App. 1977).

²²MASSACHUSETTS. *Schroeder v. Lawrence*, 372 Mass. 1, 359 N.E.2d 1301 (1977); *Haggerty v. McCarthy*, 344 Mass. 136, 181 N.E.2d 562 (1962); *Harnish v. Children's Hospital Medical Center*, 439 N.E.2d 240, 387 Mass. 152 (1982); *Halley v. Birbiglia*, 458 N.E.2d 710, 390 Mass. 540 (1983). Under *Halley*, the physician must divulge information sufficient to enable a patient to make an informed judgment about whether to give or withhold consent. *Harnish* appears to commend *Canterbury* but balances the patient's right to know with the burden to

disclose on the doctor. MASS. ANN. LAWS ch. 112 §§12Q, 12S (Michie/Law. Coop. 1985) require the physician to inform the patient of risks of and alternatives to abortion.

²³MICHIGAN. *Roberts v. Young*, 369 Mich. 133, 119 N.W. 2d 627 (1963); *Marchlewicz v. Stanton*, 213 N.W.2d 317, 50 Mich. App. 344 (1973).

²⁴MINNESOTA. *Plutshack v. University of Minn. Hospitals*, 316 N.W.2d 1 (Minn. 1982); *Cornfeldt v. Tongren*, 262 N.W. 2d 684 (Minn. 1977); MINN. STAT. ANN. §144.651 (West Supp. 1982). See also *Reinhardt v. Colton*, 337 N.W.2d 88 (Minn. 1983).

²⁵MISSISSIPPI. *Ross v. Hodges*, 234 So. 2d 905 (Miss. 1970).

²⁶MISSOURI. *Aiken v. Carey*, 396 S.W.2d 668 (Mo. 1965); *Eichelberger v. Barnes Hospital*, 655 S.W.2d 699 (Mo. App. 1983); *Kinser v. Elkadi*, 674 S.W.2d 226 (Mo. App. 1984). Missouri has undertaken to safeguard patient autonomy and "truly informed consent" where abortion is involved. MO. ANN. STAT. §188.039 (Vernon) requires physician disclosure of risks, gestational age of fetus, and alternatives to abortion.

²⁷MONTANA. *Negaard v. Estate of Feda*, 152 Mont. 47, 446 P.2d 436 (1968); *Llera v. Wisner*, 557 P.2d 805 (Mont. 1976); *Collins v. Itoh*, 503 P.2d 36 (Mont. 1972). MONT. CODE ANN. 50-20-104, 50-20-106 provides an exception for abortion to Montana's physician paternalism rule. Doctors must provide information on abortion procedures, consequences, and alternatives.

²⁸NEBRASKA. No case law. NEB. REV. STAT. §44-2816 (1978).

²⁹NEVADA. *Corn v. French*, 71 Nev. 289, 280 P.2d 173 (1955); NEV. REV. STAT. §41A.110.120 (1981). Under the Nevada statute, neither the "physician paternalism" nor "patient autonomy" rule is adopted. Instead the statute delineates information that must be provided for patient

consent. This includes the general nature of the procedure to be undertaken, its risks, and any alternative treatments feasible. To that extent, the statute follows the "patient autonomy" rule.

³⁰NEW HAMPSHIRE. *Folger v. Corbett*, 118 N.H. 737, 394 A.2d 63 (1978); N.H. REV. STAT. ANN. §507-C (Supp. 1981). Declared void by the Supreme Court of New Hampshire in *Carson v. Maurer*, 120 N.H. 925, 424 A.2d 825 (1980).

³¹NEW JERSEY. *Kaplan v. Haines*, 96 N.J. Super. 242, 232 A.2d 840 (1967), *aff'd* 51 N.J. 404, 241 A.2d 235 (1968); *Calabrese v. Trenton State College*, 392 A.2d 600, 162 N.J. Super. 145 (1978).

³²NEW MEXICO. *Henning v. Parsons*, 95 N.M. 454, 623 P.2d 574 (1980).

³³NEW YORK. *Karlsons v. Guerinot*, 57 A.D.2d 73, 394 N.Y.S.2d 933 (App. Div. 1977); N.Y. PUBLIC HEALTH LAW §2805-d (Consol. Supp. 1984). See also *Nisenholtz v. Mount Sinai Hospital*, 483 N.Y.S.2d 568 (N.Y. Sup. Ct. 1984); *Bellier v. Bazan*, 478 N.Y.S.2d 562 (N.Y. Sup. Ct. 1984). Applying §2805-d, the *Nisenholtz* court held the physician must disclose information that would "enable a reasonably prudent patient to make a knowledgeable evaluation of whether to submit to" a procedure.

³⁴NORTH CAROLINA. *Butler v. Berkeley*, 25 N.C. App. 325, 213 S.E.2d 571 (Ct. App. 1975); N.C. GEN. STAT. §90-21.13 (1981). Under the statute, a disclosure consistent with general medical practice is sufficient only if such disclosure gives the patient a general understanding of the treatment and its recognized risks. See also *Azzolino v. Dingfelder*, 322 S.E.2d 567 (N.C. App. 1984); *Brigham v. Hicks*, 260 S.E.2d 435 (N.C. App. 1979); *Nelson v. Patrick*, 326 S.E.2d 45 (N.C. App. 1985).

³⁵NORTH DAKOTA. *Walker v. North Dakota Eye Clinic*, 415 F. Supp. 891 (D.N.D. 1976); N.D. CENT. CODE

§26-40.1-04 to -05 (1978). Statute declared unconstitutional in *Arneson v. Olsen*, 270 N.W.2d 125 (N.D. 1978) and repealed 1983. *Lemke v. United States*, 557 F.Supp. 1205 (D.N.D. 1983); *Winkjer v. Herr*, 277 N.W. 2d 579 (N.D. 1979). Prior to *Lemke* and *Winkjer*, North Dakota adhered to a physician paternalism standard. However, as the federal court noted in *Lemke*, the North Dakota Supreme Court, while discussing both the patient autonomy and physician paternalism options in *Winkjer*, refused to explicitly adopt either standard.

³⁶OHIO. *Congrove v. Holmes*, 37 Ohio Misc. 95, 308 N.E.2d 765 (Comm. Pleas 1973); OHIO REV. CODE ANN. §2317.54 (Baldwin Supp. 1984). See also *Siegel v. Mt. Sinai Hospital of Cleveland*, 403 N.E.2d 202, 62 Ohio App. 2d 12 (1978). There is no therapeutic exception in the relevant Ohio cases.

³⁷OKLAHOMA. *Lambert v. Park*, 597 F.2d 236 (10th Cir. 1979). In *Lambert*, the Tenth Circuit adopted the "patient autonomy" rule for Oklahoma. After discussing several reasons for adopting the "patient autonomy" approach, the court said:

We have chosen between the tests only because the Oklahoma Court has indicated it would do so. The Court need not, however, consider itself so limited. The better practice would be to adopt a rule allowing for the application of whichever test best comports with the theories of the parties and the evidence produced during the trial.

Lambert v. Park, 597 F.2d at 199. See also *Scott v. Bradford*, 606 P.2d 554 (Okla. 1979). The Oklahoma Supreme Court explicitly adopted the patient autonomy standard in the *Scott* case, although it provided for a therapeutic exception.

³⁸OREGON. *Holland v. Sisters of St. Joseph of Peace*, 270 Or. 129, 522 P.2d 208 (1974); OR. REV. STAT. §677.097 (1981). See also *Creasy v. Hogan*, 617 P.2d 1377, 289 Or. 733 (1980). *Creasy* applied and supplemented the holding in

Holland, providing a therapeutic exception to the general rule of patient autonomy.

³⁹PENNSYLVANIA. *Jeffries v. McCague*, 242 Pa. Super. 76, 363 A.2d 1167 (1976); *Cooper v. Roberts*, 220 Pa. Super. 260, 286 A.2d 647 (1971); PA. STAT. ANN. tit. 40, §1301.103 (Purdon Supp. 1982). See also *Defulvio v. Holst*, 414 A.2d 1087 (Pa. Super. 1979). There is no therapeutic exception in Pennsylvania.

⁴⁰PUERTO RICO. *Torres Perez v. Hospital Doctor Susoni*, 95 P.R.R. 845 (1968).

⁴¹RHODE ISLAND. *Wilkinson v. Vesey*, 110 R.I. 606, 295 A.2d 676 (1972); *Beauvais v. Notre Dame Hospital*, 387 A.2d 689 (R.I. 1978). The cases applying the patient autonomy rule make no mention of the therapeutic exception.

⁴²SOUTH CAROLINA. *Hook v. Rothstein*, 316 S.E.2d 690 (S.C. App. 1984).

⁴³SOUTH DAKOTA. *Cunningham v. Yankton Clinic*, 262 N.W.2d 508 (S.D. 1978). To date, no standard has been enunciated in South Dakota.

⁴⁴TENNESSEE. *Longmire v. Hoey*, 512 S.W.2d 307 (Tenn. Ct. App. 1974); TENN. CODE ANN. §29-26-118 (Supp. 1984). See also *German v. Nichopoulos*, 577 S.W.2d 197 (Tenn. Ct. App. 1978). Tennessee requires the physician to inform the patient of the risks of and alternatives to abortion as well as the age of the fetus. TENN. CODE ANN. §39-4-202 (1984 Supp.).

⁴⁵TEXAS. *Karp v. Cooley*, 493 F.2d 408 (5th Cir. 1974); TEX. REV. CIV. STAT. ANN. art. 4590, §§6.02-.07 (Vernon Supp. 1982), implemented by 3 Tex. Reg. 4293 (1978). See also *Peterson v. Shields*, 652 S.W.2d 929 (Tex. 1983). Until the medical disclosure panel, created by statute, promulgates standards of disclosure, doctors must disclose information that would influence a reasonable person. *Barclay v. Campbell*, 683 S.W.2d 498 (Tex. Ct. App. 1984).

provides for an exception to this reasonable person rule where disclosure is not medically feasible.

⁴⁶UTAH. *Ficklin v. McFarlane*, 550 P.2d 1295 (Utah 1976); UTAH CODE ANN. §78-14-5 (1977). See also *Reiser v. Lohner*, 641 P.2d 93 (Utah 1982); *Nixdorf v. Hicken*, 612 P.2d 348 (Utah 1980). UTAH CODE ANN. §76-7-305.5 requires informed consent for abortion. The physician must inform the patient of the procedure, risks, alternatives, and physical characteristics of a normal unborn child.

⁴⁷VERMONT. *Small v. Gifford Memorial Hospital*, 133 Vt. 552, 349 A.2d 703 (1975); VT. STAT. ANN. tit. 12, §1909 (Supp. 1981). Under *Small*, the Vermont Supreme Court adopted the "patient autonomy" approach. The statute, however, though prescribing the elements of information that must be disclosed—i.e. the alternatives to the treatment or diagnosis and the risks and benefits involved—incorporates these requirements in a "physician paternalism" approach. See also *Perkins v. Windsor Hospital Corp.*, 455 A.2d 810 (Vt. 1982).

⁴⁸VIRGINIA. *Bly v. Rhoads*, 216 Va. 645, 222 S.E.2d 783 (1976). VA. CODE §18.2-76 (1982) (statute requiring informed consent for abortion).

⁴⁹WASHINGTON. *Miller v. Kennedy*, 11 Wash. App. 272, 522 P.2d 852 (Ct. App. 1974), *aff'd*, 85 Wash. 2d 151, 530 P.2d 334 (1975); WASH. REV. CODE ANN. §§7.70.050-.060 (Pocket Part 1985). See also *Adams v. Richland Clinic, Inc.*, 681 P.2d 1305, 37 Wash. App. 650 (1984); *Holt v. Nelson*, 523 P.2d 211, 11 Wash. App. 230 (1974). These cases establish a lay standard of disclosure with a therapeutic exception.

⁵⁰WEST VIRGINIA. *Cross v. Trapp*, 294 S.E.2d 446 (W. Va. 1982), adopts a "patient need" standard with a therapeutic exception.

⁵¹WISCONSIN. *Trogun v. Fruchtman*, 58 Wis.2d 569, 207 N.W.2d 297 (1973); *Scaria v. St. Paul Fire & Marine Insurance Co.*, 227 N.W.2d 647 (Wis. 1975).

⁵²WYOMING. *Govin v. Hunter*, 374 P.2d 421 (Wyo. 1962); *Stundon v. Stadnick*, 469 P.2d 16 (Wyo. 1970).